Issues in Workers' Comp
Other Programs Within the Division

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EK HEALTH

JUNE 21, 2013

CASE MANAGEMENT

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EK HEALTH SERVICES®, INC.

The issues are COMPLEX. The answer is SIMPLE.

What is Case Management?

Definition of Case Management

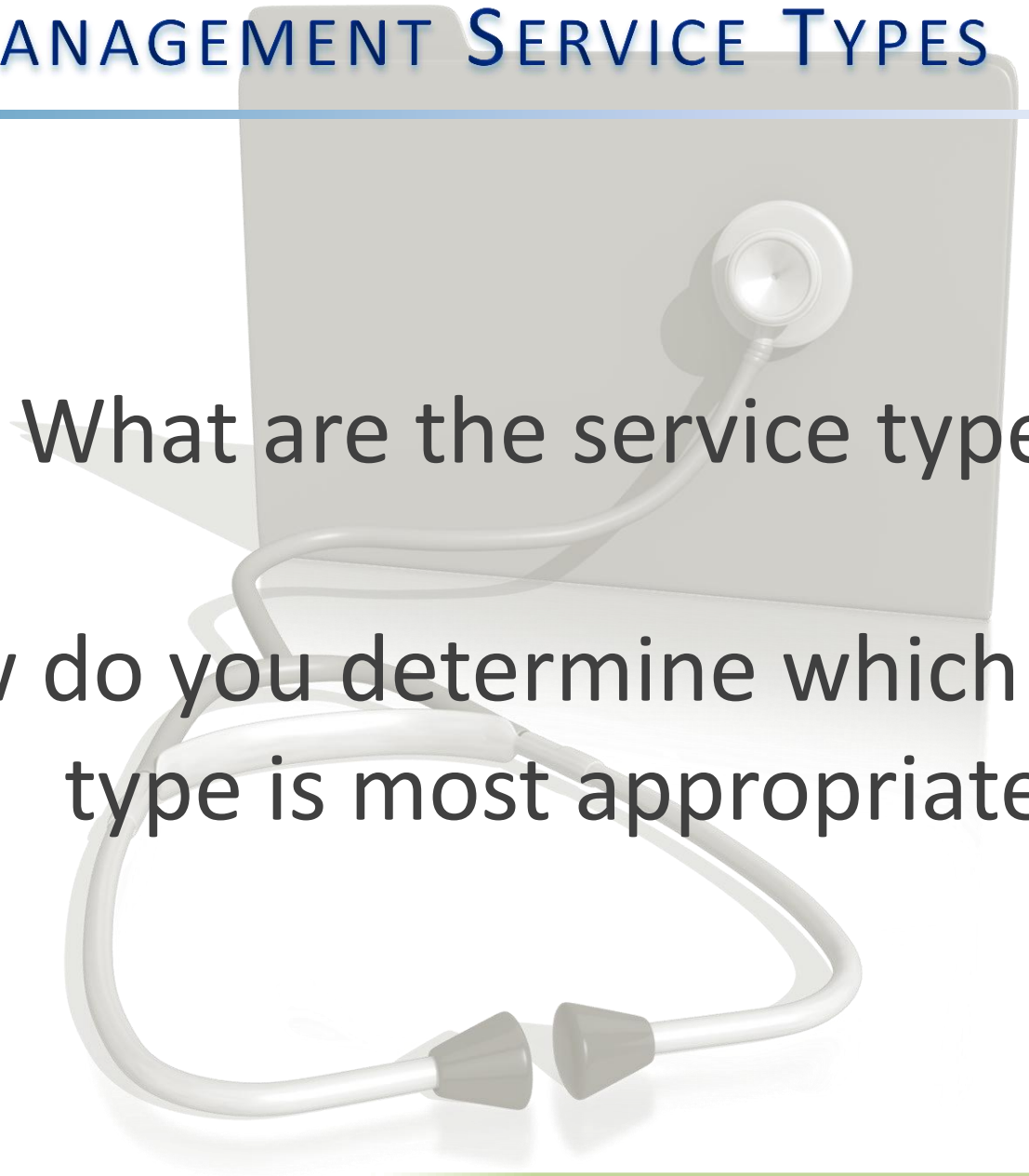
Case Management Society of America

"A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes."

Case Management roles

- Educator
- Coordinator
- Communicator
- Collaborator
- Clinician
- Utilization Manager
- Transition Planner
- Leader
- Quality Manager
- Negotiator
- Advocate
- Researcher
- Risk Manager

Case Management Service Types

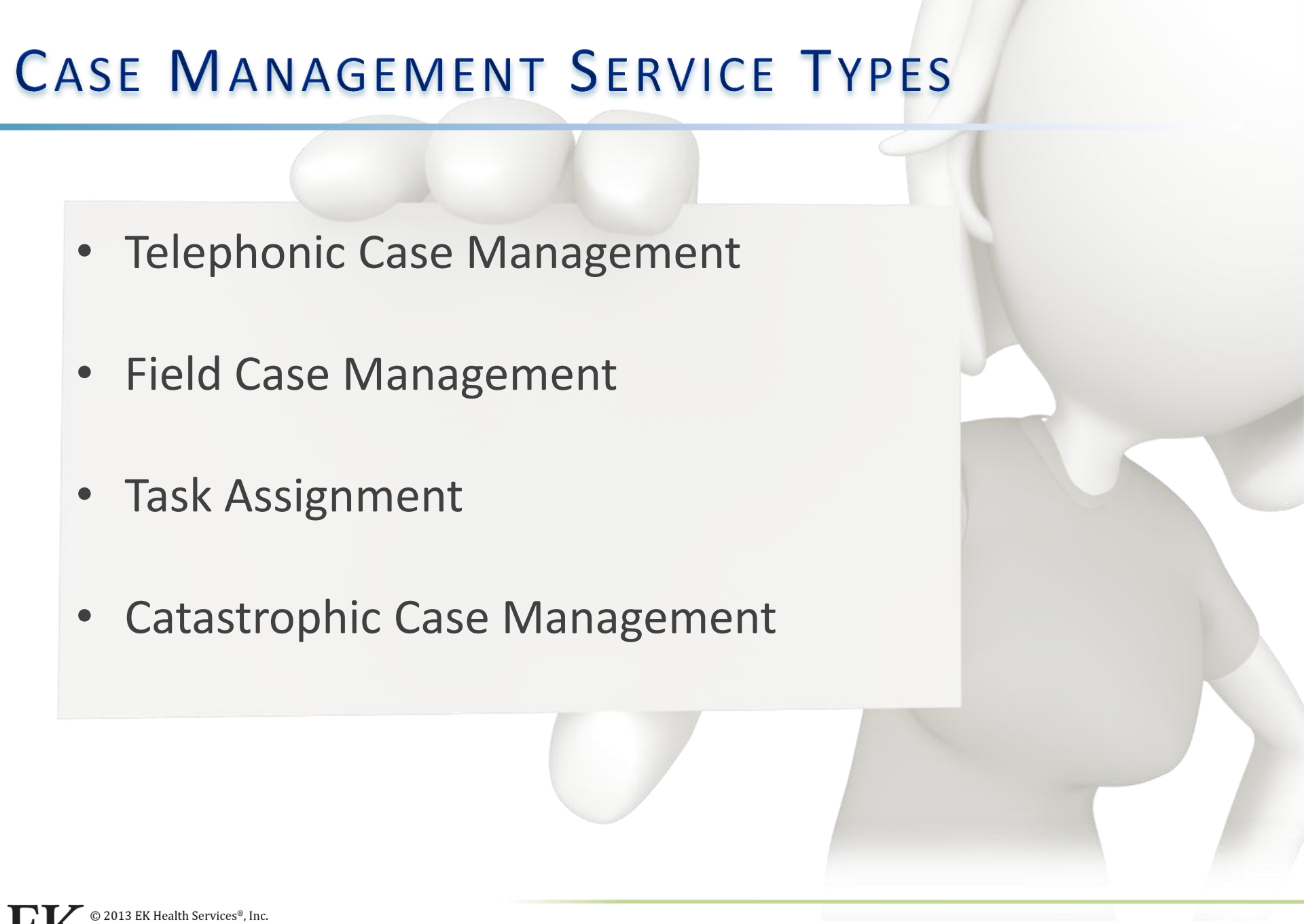


What are the service types?

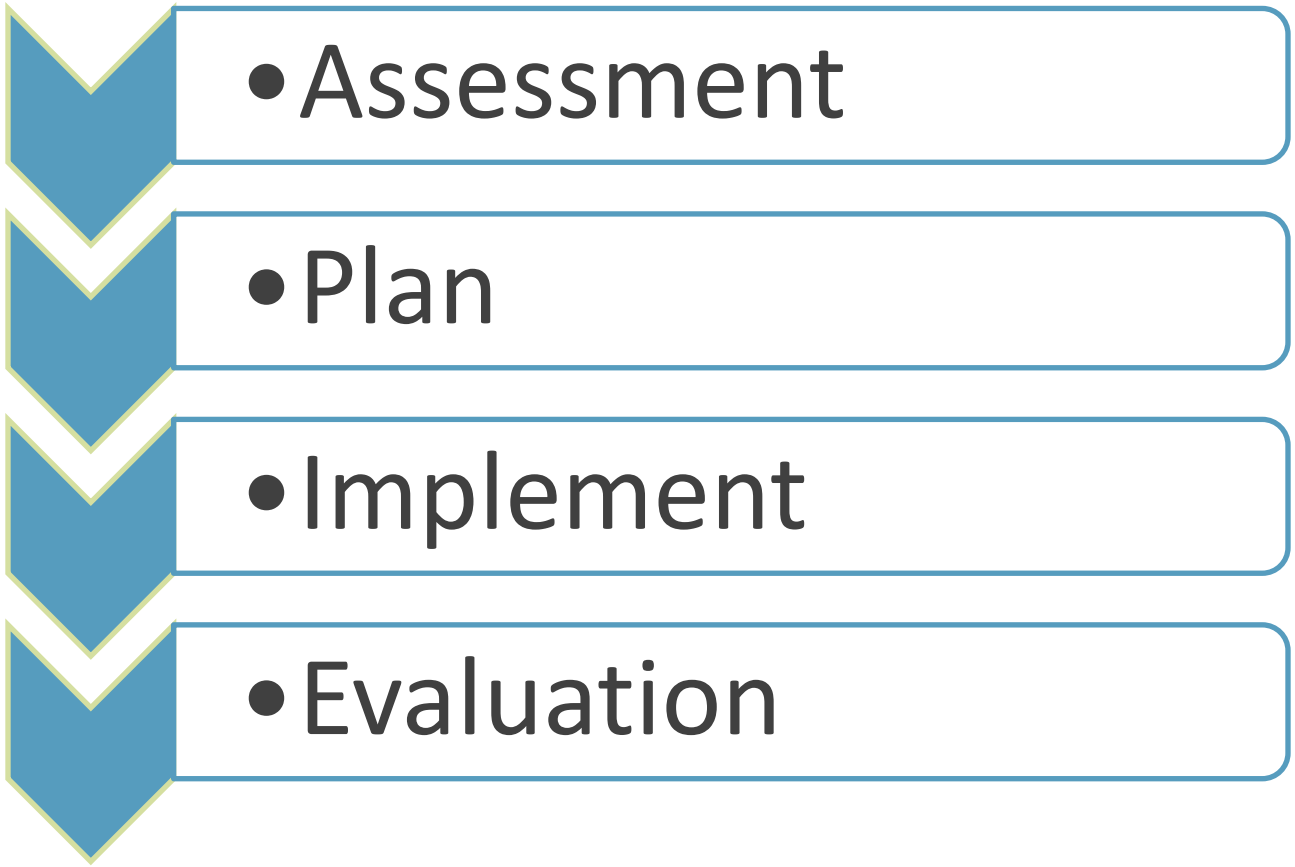
How do you determine which service type is most appropriate?

Case Management Service Types

- Telephonic Case Management
- Field Case Management
- Task Assignment
- Catastrophic Case Management

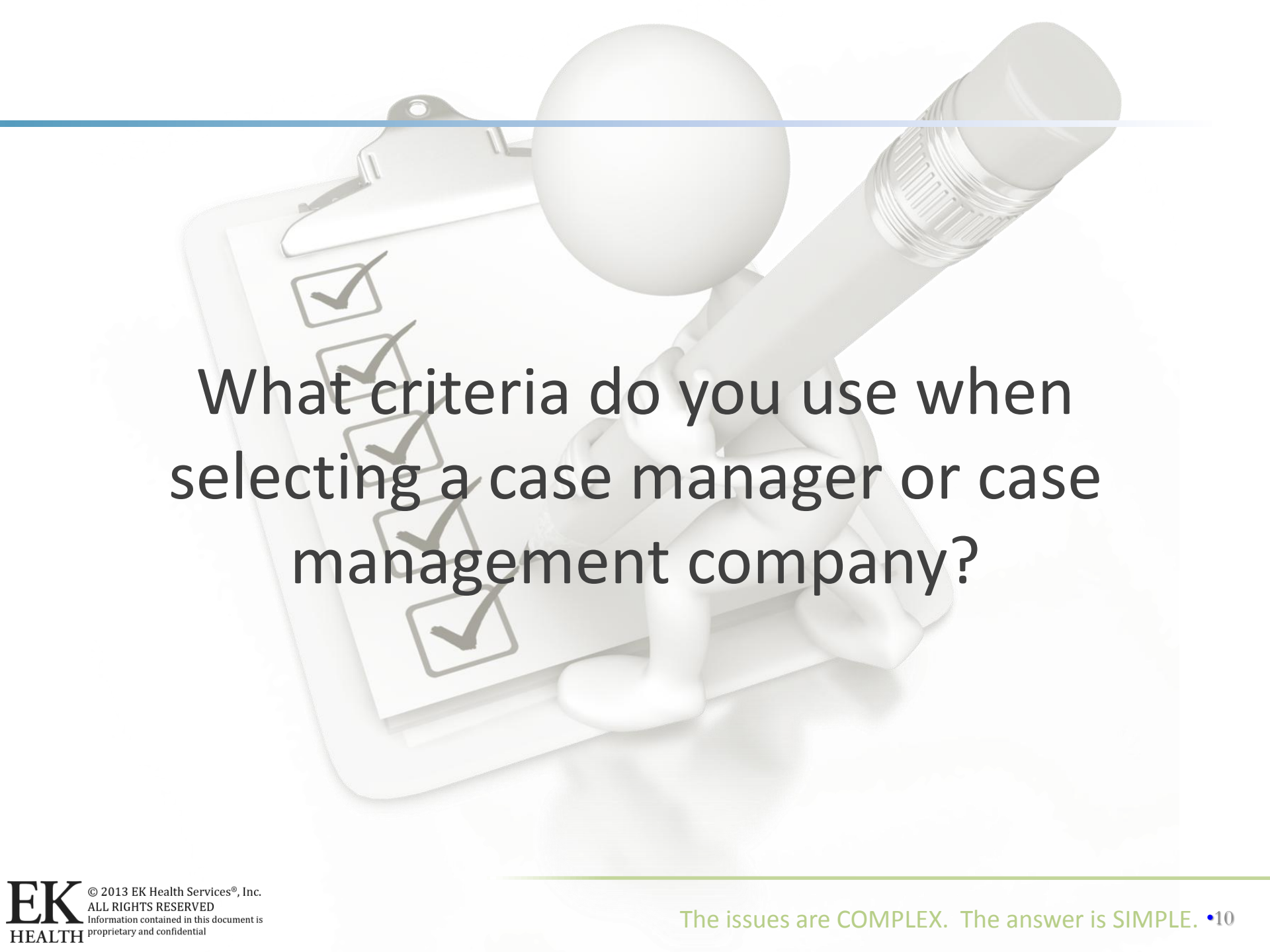


The Case Management Process



Case Management Quality Standards

- Case Assignment within 24 hours (standard assignment)
- Case Assignment within 2 hours (catastrophic case assignment)
- Initial contacts made within 24 hours
  - Claims examiner/referral source
  - IW
  - Employer if appropriate
  - Physician
  - Attorney if appropriate
- Initial report completed within 14 days
- Progress report every 30 days or after a significant event



What criteria do you use when selecting a case manager or case management company?

SUGGESTED CRITERIA

- Ethical
- Participates in on-going training
- Resourceful within the industry
- Excellent communication/negotiation skills
- Strategic/critical thinking
- Understands workers' compensation in TN

Tennessee Department of Labor

requirements for case Management

- Case Manager Registration
- Case Management Company registration
- Completion of on-line case management forms
  - Case Management Notification
  - Case Management Closure

It is part of the Case Manager's duties to present the Injured Worker with the panel of physicians from which the Injured Worker will choose an authorized doctor.

A. True

B. False

The Case Manager may request an impairment rating from a physician and may ensure that the proper edition of the AMA Guides are utilized.

✔ A. True

B. False

Tennessee Department of Labor

Case Management Policies—Part 1

- Any case manager who practices in the State of Tennessee must receive a Case Manager number from the Department of Labor, Workers' Compensation division.
- The injured worker shall have access to a local on-site Case Manager. During the life of the case, a combination of telephonic and on-site may be utilized.
- The Case Manager should not engage in any legal discussions.
- The Case Manager should not engage in any claims functions.

TENNESSEE DEPARTMENT OF LABOR

CASE MANAGEMENT POLICIES—PART 2

- A Case Manager should not present the client with the choice of 3 physicians. This should be presented by the employer and/or the carrier. A Case Manager may assist the employer and/or the carrier in deciding which physicians to utilize. A Case Manager may make the appointment once the choice is made.

- A Case Manager may request an impairment rating from the physician and ensure that he consults the American Medical Association Guidelines. A Case Manager may not engage in discussions as to what the impairment rating should be.

The Case Manager may present medical records to an authorized physician and enter into discussions regarding the compensability of the claim with that physician.

A. True

B. False

For discussions regarding benefits, a Case Manager should refer an Injured Worker to the adjuster and/or employer.

✓ A. True

B. False

The Case Manager should always remain with the Injured Worker for the duration of a physical examination

A. True

B. False

TENNESSEE DEPARTMENT OF LABOR

CASE MANAGEMENT POLICIES

- A Case Manager may assist in the provision of pertinent medical records to physicians to determine compensability but may not enter into discussions or arguments regarding compensability.
- If the patient requires information regarding his/her benefits, the Case Manager should refer him/her to the claims adjuster or the employer.
- A Case Manager should meet with the client at the physician appointment when pertinent information is exchanged between the client, the Case Manager, and the physician to formulate treatment plans but should exit the examination room during the actual examination to allow free exchange between the client and the physician. A Case Manager shall re-enter during the treatment plan discussion. The exception is that the Case Manager may remain during the entire examination if the client and the physician request same.
- The Case Manager shall perform a job analysis to present to the physician to ensure informed decisions are made in regard to the opportunities for returning to work. Video tapes may be utilized, if so desired.

CASE MANAGEMENT POLICIES

- The Case Manager may determine if the restrictions provided by the physicians meet the job description provided.

- If an Independent Medical Examination (IME) is implemented, the Case Manager should provide these results to the original treating physician.

Who may the Case manager contact to coordinate an Injured Worker's healthcare?

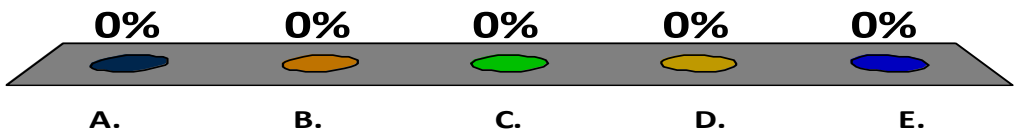
A. The Injured Worker

B. The Healthcare Providers

C. The Employer

D. The Parties' Attorneys

E. All of the above



TENNESSEE DEPARTMENT OF LABOR

CASE MANAGEMENT PROTOCOLS—PART 1

- The Case Manager has the authority under the Tennessee Workers' Compensation Law to contact the injured worker, employer, insurer, third party administrator, legal representative and all health care providers involved in a Workers' Compensation case to coordinate the medical care services provided to employees claiming benefits under the Tennessee Workers' Compensation Law.

- All parties involved have the duty and responsibility under the statute to cooperate with the Case Manager in the exchange of information so the Case Manager may develop a treatment plan to provide appropriate medical care services for return to work with due regard for the employee's recovery and limitation to work.

TENNESSEE DEPARTMENT OF LABOR

CASE MANAGEMENT PROTOCOLS—PART 2

- The Case Manager shall also provide access to the Case Manager's report to all parties involved in the claim.
- If represented by counsel, the Case Manager shall attempt to contact the attorney before talking to the injured worker to explain the purpose of case management.
- Attorney can request a meeting with the Case Manager or request initial meeting take place in the attorney office.

TENNESSEE DEPARTMENT OF LABOR

CASE MANAGEMENT PROTOCOLS—PART 1

- All written communication must be provided to the attorney unless the attorney gives permission to do otherwise.
- All health care providers should allow the Case Manager access to all pertinent medical records involving the injured worker.
- Any incompatibility between the Case Manager and the injured worker, health care provider, employer, or attorney shall be resolved by the Case Manager's parent company. If the parent company cannot resolve, the case will be referred to the medical director for disposition.

TENNESSEE DEPARTMENT OF LABOR

CASE MANAGEMENT PROTOCOLS—PART 2

- The Case Manager is not allowed to enter during the examination unless permission is granted by both the patient and the physician.
- Physicians may not charge for consulting with Case Managers after the initial examination or follow up visits by the injured employee to the physician's office. Physicians may charge for prolonged consults with the Case Manager if the appointment is requested by the Case Manager. Physicians may charge for special request s i.e. review of files, etc.

Questions?

Issues Associated with Regulatory Compliance in the Workers' Compensation Law

COMPLIANCE PROGRAM

- Investigates and penalizes employers who fail to provide workers' compensation coverage
- Educates relevant parties as to noncompliance and the Exemption Registry
- Investigates and penalizes (July 1, 2013) for misclassification and premium avoidance
- Monitors Specialists' orders for compliance, unpaid benefits or untimely paid benefits
- Assesses and collects penalties for noncompliance

The Compliance Program investigates and monitors the following penalties:

- Non-compliance with a Specialist's Order
- Unpaid or untimely paid Temporary Benefits
- Claims Form Filing Violations
- BRC Violations
- Medical Fee Schedule
- Medical Impairment Rating Registry
- Uninsured Employers Fund
- Employee Misclassification

A 10 K Penalty is assessed for failure to pay or failure to untimely pay temporary disability benefits.

A. True

✓ B. False

Non-Compliance with a Workers' Compensation Specialist's Order

- Pursuant to T.C.A. Section 50-6-238, a Specialist is authorized to issue Orders for Benefits.

- Employers/carriers/trusts are required to comply with the Specialist's Benefit Order within 15 calendar days of receipt, unless a request for Administrative Review is filed.

Non-Compliance Cont.

- If administrative review is requested, the obligation to comply with the Specialist's Benefit Order is suspended until the administrative review is resolved.

- If the Administrative Review Order requires the payment of benefits, the employer/carrier/trust must comply with the Administrative Review Order within **10 calendar days** of receipt.

Non-Compliance Cont.

- Failure to comply with an Order by a Specialist within 15 calendar days or an Order by an Administrator's Designee within 10 calendar days SHALL result in a penalty of $10,000.00.
- Continued failure to comply 21 days after receipt of the Compliance Order SHALL result in an additional penalty of $1,000.00 per day.

The Standard of Review in 10 K Penalty Cases is Strict Liability

✓ A. True

B. False

Non-Compliance Cont.

- Any party aggrieved by a Non-compliance penalty has the right to appeal the penalty pursuant to the Uniform Administrative Procedures Act.
- Any timely filed appeal suspends the obligation to comply with the Penalty Order until the appeal is resolved.

25% Penalties

- Pursuant to T.C.A. Section 50-6-205, a Specialist is authorized to assess civil penalties for unpaid or untimely paid temporary benefits.
- The penalty, if assessed, is 25% of the unpaid or untimely paid benefits and is payable directly to the claimant.

25% Penalties Cont.

- The 25% penalty is discretionary. The standard of review is good faith. Generally, good faith means fairness, reasonableness, due care and due diligence.

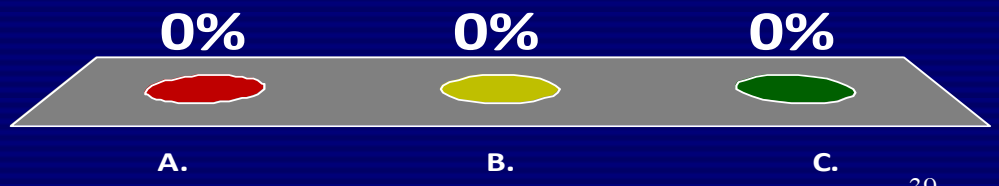
- A good faith analysis is a fact-dependent evaluation of the claim management and what facts or proof existed to support the action or inaction of the payor.

Which of the following is the proper Standard of Review for 25% Penalty Cases?

A. Strict liability

B. Substantial and Material

C. Preponderance of the Evidence



25% Penalties Cont.

- Any party aggrieved by a 25% penalty assessment has the right to appeal the penalty pursuant to the Uniform Administrative Procedures Act.
- Any timely filed appeal suspends the obligation to comply with the 25% penalty order until the appeal is resolved.

Claims Form Filing Violations

- The statute and rules require the timely filing of various claims forms. The standard of review is good faith.
- The most common & most important is the First Report of Injury form (C-20).
- The C-20 must be filed by the employer within 1 business day with the carrier, claims administrator, or trust.

Claims Cont.

- The carrier, claims administrator, or trust must file the C-20 electronically through EDI with the Division no later than 14 days after the accident.
- The C-20 must be filed whenever a claim results in expenses being incurred – i.e. including medical only claims.

Claims Cont.

The statute and rules also require the timely filing of various other claims forms including, but not limited to:

- Notice of 1st Payment (C-22)
- Notice of Denial (C-23)
- Notice of Stop or Change in Benefit Payments (C-26)

BRC's

- Pursuant to T.C.A. Section 50-6-237, both the employee and the employer shall provide a person with full settlement authority at the BRC.

- Furthermore, if a party or their representative is not prepared to mediate or is not mediating in good faith, they may be assessed a penalty.

Medical Fee Schedule

- The mandatory WC Medical Fee Schedule is based on **Medicare,** provides a ceiling or **"cap"** on medical fees, and applies to all WC medical services provided on or after July 1, 2005.

- The Rules provide for a penalty against both the provider & payor of up to $10,000.00 if there is a pattern or practice of violating the medical fee schedule.

Medical Impairment Rating Registry (MIRR)

- MIRR was established in the 2004 Reform Act to settle disputes over permanent impairment ratings only. MIRR is available for injuries occurring on or after July 1, 2005 only.
- Membership, operation, procedures, & costs of MIRR are detailed in the MIRR Rules.
- Violation of the MIRR Rules may result in a penalty of up to $100.00 for each violation.

Penalty Payments

- Claims Form, BRC, Medical Fee Schedule, and Medical Impairment Rating Registry penalties are all payable to and become part of the Second Injury Fund.

- All the penalties above provide for an appeal pursuant to the Uniform Administrative Procedures Act.

Compliance Program
Penalty Unit – Contact Info

- **Legal Assistant** **Robin Stockman**
  (615) 253-5477
- **Compliance Specialist** **Robert Marioni**
  (615) 253-1471
- **Compliance Specialist** **April Verdoni**
  (615) 532-1309
- Send orders and proof of compliance to:

WCCompliance.Program@tn.gov

COMPLIANCE PROGRAM
UNINSURED EMPLOYERS FUND (UEF)

Important Points:

- Any entity engaged in the construction industry, including principal contractors, intermediate contractors or subcontractors, is required to carry workers' compensation insurance on their employees, regardless of the number of employees.

- Effective March 1, 2011, owners of construction businesses are also required to carry workers' compensation coverage on themselves or be listed on the Exemption Registry.

Compliance Program (UEF) Cont.

- In other industries, employers with five (5) or more employees, including part-time employees, must carry workers' compensation insurance. Family members and corporate officers are included in the count if they meet the definition of employee

Standard of Review

- Strict Liability – Either the Employer has continuous and current coverage or not.

Compliance Program – Employee Misclassification Education and Enforcement Fund (EMEEF)

- Identifies and penalizes employers who misclassify workers, under report the number of employees and/or payroll, and/or misrepresent the type of work that is being performed.

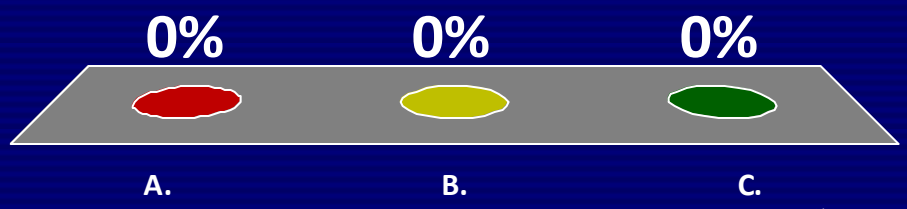
- Investigates unlawful deductions (monies deducted from an employee's pay for workers' compensation benefits).

When should we use T.C.A. § 50-6-902 (as opposed to § 50-6-113?

A. Only in non-construction cases

✓ B. Only in construction cases

C. You may use either at your leisure



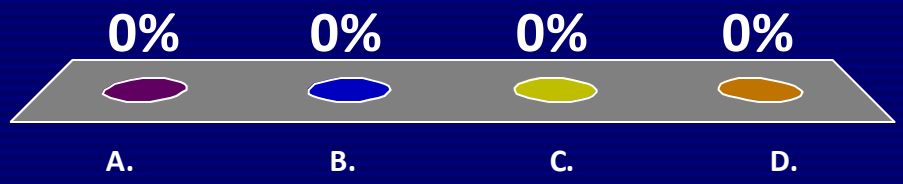
How do we determine if an employer is engaged in the construction industry?

A. Use the NCCI Contracting Industry Group Codes

B. Call the Compliance Director

C. Call the Attorneys in the Compliance Program

D. Determine if the employer is altering, modifying or making repairs to a structure



Answer:

- A. Refer to the National Council on Compensation Insurance (NCCI) Contracting Industry Group Codes.
- http://www.tn.gov/insurance/documents/NCCI_ContractingIndustryGroupCodes.pdf
- *If an employer has a question as to whether he is engaged in construction, refer him to NCCI at 1.800.622.4123 to obtain the four-digit classification code.*

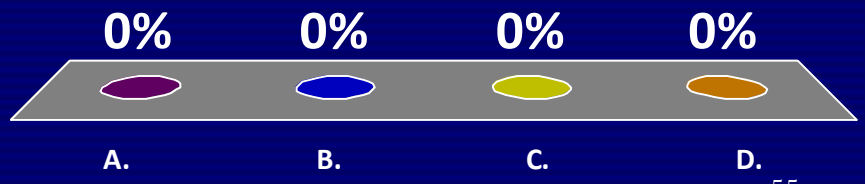
Which of the following is not one of the seven (7) Factors used to determine if someone is an employee or not?

A. The right to control the conduct of the work

B. Method of payment

C. Economic loss or financial risk

D. Freedom to offer services to other entities



Answer:

- C. Economic loss or financial risk

- Although the IRS considers whether there is an economic loss or financial risk incurred beyond the normal loss of salary in its determination, this factor is not listed in T.C.A. § 50-6-102 (10) (D).

COMPLIANCE PROGRAM UEF/EMEEF CONTACT INFORMATION

Attorney:	**Blake Alford**	**615-741-1237**
Attorney:	**Adrienne Fazio**	**615-253-9997**
WCCS Chattanooga:	**Kara Rhoden**	**423-634-2141**
WCCS Jackson:	**Vacant**	
WCCS Knoxville:	**Deborah Rolen**	**865-594-5188**
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ISSUES IN WORKERS' COMPENSATION – OTHER PROGRAMS WITHIN THE DIVISION

FROM A DEFENSE ATTORNEY'S PERSPECTIVE

Mary Dee Allen, Esq.

Knoxville Morristown Cookeville Nashville

Scenario One

Employee files an RFA for discovery asking for 20 years of personnel records on all employees who have filed comp claims.

Employer responds but RFA is granted.

What recourse does an employer have?

Scenario One

A. Fail to Comply.

Pros:

Once the information is produced, the toothpaste is out of the tube, so to speak.

Cons:

This course of action is quite risky. The penalty provisions allow for significant penalties, some daily in nature for failure to abide by the Order. Given where these RFAs normally occur, it could be months or years before the Order is reviewed.

Scenario One

B. Comply.

As stated earlier, once the information is produced, it cannot be retracted. The other side now has the records for use throughout the claim. Of course, under this option, an employer would not face penalties.

Scenario One

C. Appeal?

There does not appear to be such an option within the current procedures with respect to discovery orders.

Scenario One

D. File Motion for Protective Order.

This scenario highlights a procedural issue with discovery RFAs and Orders. The statute gives discovery specialists the authority to utilize protective orders. However, no procedure is outlined with respect to their use.

Issues raised: What is the time frame for filing such a motion? Response time? Review of Orders concerning such motions?

Scenario Two

Employee works for manufacturer for a few weeks. Employee is found deceased in the break room after break. The cause of death is unknown.

Scenario Two

Issue: Must employer file a first report of injury simply because the ‘injury’ occurred on premises?

Scenario Two

Answer: Maybe.

Comparing the Court system with the Department, a different standard has been applied for when the First Report must be filed.

What options does an employer have?

Scenario Two

A. File a First Report Immediately.

Pros:

This action would comply with the current regulations and the interpretation of same. The employer would avoid any possible penalty.

Cons:

There is no causative link. Filing a first report may give the impression that the event is work-related when no proof of such exists.

Scenario Two

B. Do Nothing.

Pros:

Since there is no proof of causation or ‘course and scope’, the employer should not have to treat this as a work-related event. Thus, no first report need be filed.

Cons:

Based upon the liberal view of the definition of work-relatedness, a penalty could be assessed against the employer for the late filing of the first report.

Scenario Three

Employee seeks treatment for shoulder injury. ATP seeks UR determination for surgery, which is denied. Employer files Notice of Controversy of claim based upon several grounds, including compensability and course and scope. Employee appeals UR denial and denial is reversed by the Department. The Department then enters an Order requiring that the employer authorize the surgery.

Scenario Three

Issue: Should the employer be penalized for failure to authorize the surgical procedure?

Scenario Three

The answer is unclear. The Department has the authority to issue Orders compelling the authorization of treatment following UR. If the employer has controverted or denied the claim in the interim, this could present problems as far as compliance with the Order is concerned.

What options does an employer have?

Scenario Three

A. File request for Administrative Review of the UR decision.

Pros:

Employer will have another person look at the decision and will (hopefully) avoid penalties for non-compliance with the original Order.

Scenario Three

B. File RFA to conclusively determine compensability.

Pros:

If filed in conjunction with the request for Administrative Review, the RFA will (hopefully) allow the compensability denial to be tested and, if upheld, allow amendment of the UR Order.

Cons:

The current procedures do not set forth whether such action would hold potential penalties in abeyance. Thus, it is unclear what would occur if the compensability denial is overturned, especially if such decision comes after an unfavorable Administrative Review decision.

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ADMINISTRATIVE REVIEW PROGRAM

The Sixteenth Annual
Tennessee Workers' Compensation
Educational Conference

June 21, 2013

History and Purpose

Administrative Review is an informal process of appeal intended to provide parties to a workers' compensation claim an opportunity for review of Orders issued by Benefit Review Specialists.

The main purpose of the Administrative Review Program is to carefully review Benefit Review Orders for Temporary Disability Benefits and Medical Benefits pursuant to Tenn. Code Ann. Section 50-6-238(d).

The Standard of Review for Administrative Review of a Benefit Review Order contains all of the following elements ***Except***:

25% A. Benefit Review findings shall be accompanied by a presumption of correctness.

25% B. New information will be accepted only in limited circumstances.

25% C. The Benefit Review Order will be Reversed if the preponderance of the evidence indicates a different result.

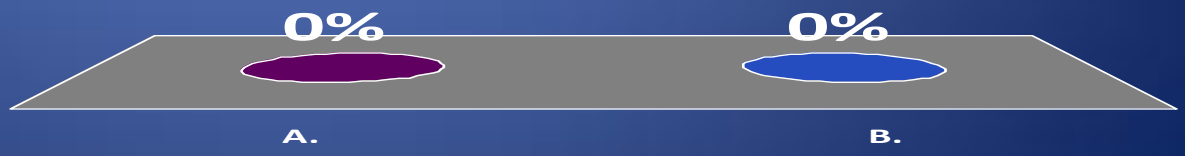
25% D. All of the above are included in the Standard of Review for Administrative Review

The Administrative Review Standard of Review shall be *de novo* upon the information and documentation provided by Benefit Review, accompanied by a presumption of the correctness of the Benefit Review findings unless the preponderance of the information and documentation is otherwise. *See* Tenn. Code Ann. Section 50-6-225 (e)(2).

The Benefit Review Workers' Compensation Specialist 4 who issued the Benefit Review Order will provide to Administrative Review a complete copy of all documents and information which have been considered in the Benefit Review process.

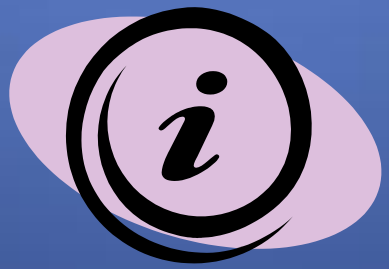
A. True

B. False



Answer:

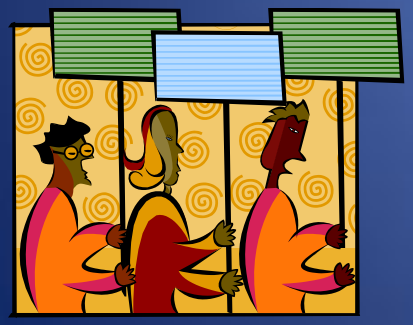
True: This is the information upon which the Administrative Review will be primarily based.



Answer:

True: (continued)

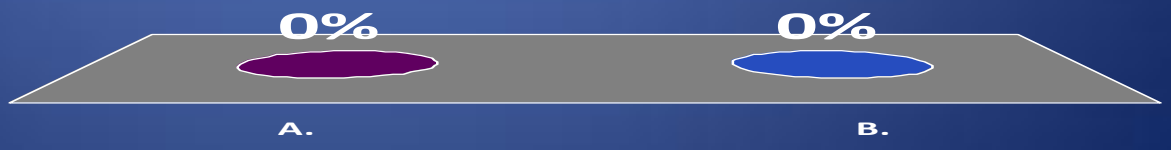
Therefore, it is very important that the Parties provide all of the relevant information and documentation to the Benefit Review Specialists before a Benefit Review Order is issued if the Party wants the information and documentation to be considered when a decision is made concerning the workers' compensation issues raised.



General information which was available and could have reasonably been obtained and provided by a Party to the Benefit Review Specialist before the Benefit Review Order was issued will not be considered by the Administrator's Designee on Administrative Review except in limited circumstances.

✓ A. True

B. False



True: Also, upon Administrative Review, the Administrator's Designee considers only the issues which were raised by the Parties at Benefit Review. New issues may only be addressed by filing a new Form C-40A Request for Assistance (RFA) with Benefit Review.

If new information may possibly make a material difference in the benefit review decision, limited circumstances in which the new information will be accepted during the Administrative Review process include all of the following *Except*:

25% A. New information that the ATP changed his professional opinion on a pertinent issue.

25% B. New information from a physician from whom the claimant sought treatment after the employer denied the claim and did not offer a panel.

25% C. New information gathered as a result of a Benefit Review Discovery Order .

25% D. All of the above constitute limited circumstances in which materially new information may be accepted during the Administrative Review Process.

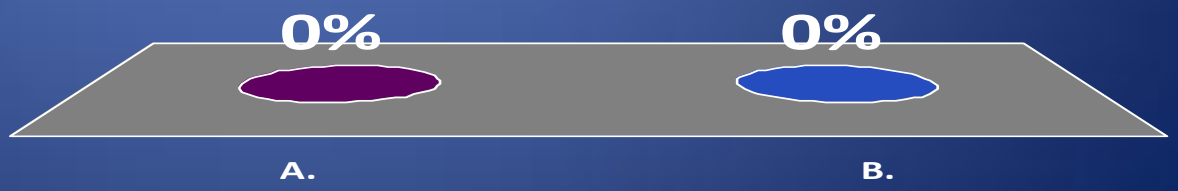
Answer:

D. All of the above constitute limited circumstances in which materially new information may be accepted during the Administrative Review process.

After receipt of a Benefit Review Order, there is a statutory time deadline for filing a Request for Administrative Review of a Workers' Compensation Specialist's Order (RFAR).

✓ A. True

B. False



Answer:

True: Pursuant to Tenn. Code Ann. Section 50-6-238(d)(1)(B)(i), a Party must file a Request for Administrative Review (RFAR) "no later than seven (7) calendar days from the date on which the party received the specialist's order that is the subject of the request." (emphasis added)

Answer:

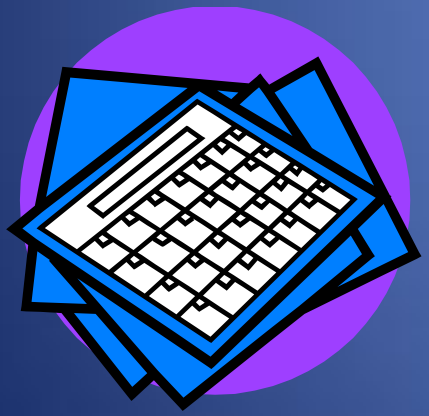
True: (continued)

Additionally, one important exception can be found in Tenn. Code Ann. Section 1-3-102, which states the following: “The time within which any act provided by law is to be done shall be computed by excluding the first day and including the last, unless the last day is a Saturday, a Sunday, or a legal holiday, and then it shall also be excluded.”

Answer:

True:

(continued)

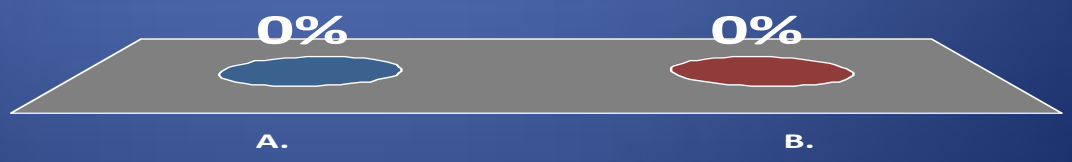


Accordingly, if the seventh calendar day falls on a Saturday, a Sunday, or a State of Tennessee holiday, the time for filing a Request for Administrative Review will be extended to the next business day.

After receipt of an Administrative Review Order, compliance with the Administrative Review Order must be achieved within fifteen (15) calendar days.

A. True

B. False



Answer:

False: Pursuant to Tenn. Code Ann. Section 50-6-238(d)(2)(B), “the party against whom the order is issued shall comply with the order within ten (10) calendar days of the receipt of the order of the … administrator’s designee.” (emphasis added)

Answer:

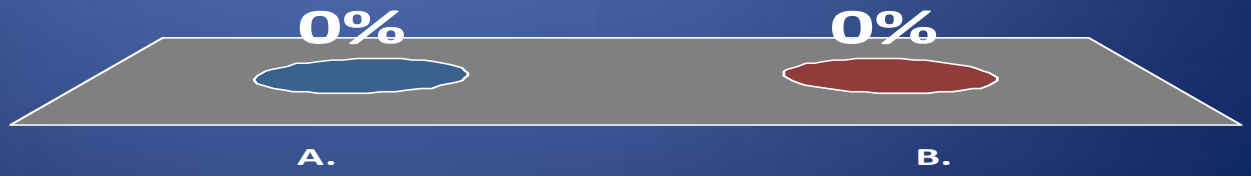
False: (continued)

However, compliance with a Benefit Review Order which is not appealed to Administrative Review must be achieved within fifteen (15) calendar days of receipt of the Benefit Review Order.

Any Workers' Compensation Specialist may serve as an Administrator's Designee?

A. True

B. False



Answer:

False: Pursuant to Tenn. Code Ann. Section 50-6-238(d)(2)(A), an "administrator's designee shall be a Tennessee licensed attorney" and "shall have a minimum of five (5) years of experience with the [Tennessee] Workers' Compensation Law."

Answer:

False: (continued)

Additionally, also pursuant to Tenn. Code Ann. Section 50-6-238(d)(2)(A), an Administrator's Designee "shall not be the specialist who issued the order that is the subject of administrative review."


THANK YOU

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